Physical Examination QualChart®

Illinois Valley Community Hospital

Printed: 11/27/2015 10:56
Time/Date Seen (If Different):

Mode of Arrival: ☐ EMS ☐ Other

Instructions: Circle pertinent positive findings. Backslash pertinent negative findings. INDICATORS: * HQI ▲ PQRS

Vital Signs: Stable except: BP ____/____ Pulse ____ R Rate ____ Temp ____

Pulse Ox: Normal Hypoxic Not Applicable ____ % on Room Air or O_2 @ ____ L/min

Cardiac Monitor: Rate: NSR Brady Tachy Rhythm: Sinus Afib Junctional Ectopy: None PVCs PACs

HISTORY:

HX from Patient Unobtainable due to: Dementia Altered Mental Status Extremis Other: ____

HX from: Patient Family / Caretaker EMS Interpreter Caseworker LMP: ____

CHIEF COMPLAINT: This is a 2 year old male / female who presents for a physical examination for: School Work DCFS (Circle if Appropriate)

Any Complaints: Yes / No exam, but mother declined the examination.

ONSET/DURATION Started ____ Min Hours Days Weeks Ago Still Present Resolved Worse Since: ____

TIMING Constant Intermittent Episodes Lasting ____ Sec Min Hours Days Weeks

SEVERITY Initially: Mild Moderate Severe Currently: Mild Moderate Severe

LOCATION

CHARACTER This mother has taken the children to three

AGGRAVATING different physicians within a week. Mother states

ALLEVIATING she believes everytime 2 year old visits Dr.

ASSOCIATED SIGNS AND SYMPTOMS Negative

RELATED HX Abuse No Other Known History - Patient in DCFS Custody Father she is being ~~rapid~~ raped by him.

REVIEW OF SYSTEMS: Pertinent Positives

Constitutional	Neg	Fever	Chills	
Eyes	Neg	Photophobia	Blurred Vision	
ENT	Neg	Sore Throat	Ear Ache	
CV	Neg	Palpitations	Chest Pain	
Resp	Neg	SOB	Cough	
GI	Neg	Vomiting	Diarrhea	
GU	Neg	Dysuria	Hematuria	
MSkeletal	Neg	Arthralgia	Myalgia	
Skin	Neg	Rash	Bruising	
Neuro	Neg	Headache	Weakness	
Psych	Neg	Anxious	Depressed	

All other systems reviewed and negative: Yes No

Levels 2 - 3: 1 System Level 4: 2 Systems Level 5: 10 Systems / Disclaimer

Additional Pertinent History:

PCP / Managing Physician(s):

Referred to ED / Clinic by: PCP / Telephone Referral / Other:

Previous Visit for Same Complaint to ED / Clinic / PCP / In-Patient Within 72 Hours / ____ Days Dx / Rx:

I have offered to examine the child. Mother states it will not find anything on her now but she smells semens of her! Mother wants me to write a statement for RAPE referral.

Rx/Treatment Compliant

PAST MEDICAL HISTORY: Previously Healthy DNR / Comfort Care Only

PMH / FH / SH: Levels 1 - 3: 0 Level 4: 1 Level 5: PMH plus FH or SH

Endocrine	DM I	DM II	Hypothyroid	Hyperthyroid	Dyslipidemia			
CV	CAD / MI	HTN	CHF	Afib	DVT			
Respiratory	COPD	Asthma	Bronchitis	Pneumonia	PE			
GI / GU	PUD / GERD	GI Bleed	Urosepsis	Diverticulitis	Gall / Kidney Stones	Chronic Kidney Dx		
Neuro / Psych	TIA / CVA	Migraine	Anxiety	Depression	Seizure	Bipolar Disorder	Schizophrenia	PTSD
Cancer	Lung	Colon	Breast	Prostate				
Surgical Hx	None	Unknown						

Immunizations: Unknown Tetanus UTD Not UTD

* Pneumococcal * Influenza within 12 months

FAMILY HISTORY: Negative

Heart / HTN ____

Diabetes ____

Other: ____

SOCIAL HISTORY: Negative

Smoking ____ ppd x ____ yrs. * Patient Advised to Stop

Cessation Counseling Time: 3+ min - 10 min / 10+ min.

* ETOH / Drug Use ____

Occupation: ____

Lives: Alone With Family At Nursing Home

KRAMER, MADELINE H
VISIT ID: 11125434
01/20/2013 2Y/F
ATT: SABIR, MUHAMMAD
PCP: PERSAUD, PITAMBER
MRN: 261617

DATE 05/13/2016

Physical Examination QualChart®

Illinois Valley Community Hospital

PHYSICAL EXAMINATION: EXAM LIMITED DUE TO: Dementia Altered Mental Status Extremis Other: _____

		Normal Findings:	Abnormal Findings:	Complaint-Specific Findings
Appearance	Normal	Well-Appearing No Pain Distress Well-Nourished	*Ill-Appearing: Mild Mod Severe* *Pain Distress: Mild Mod Severe* *Obese / Thin / Cachectic*	
Eyes	Normal	PERL / EOMI Conjunctiva Clear	*R Pupil _____ L Pupil _____* *Conjunctiva Inflammed*	
ENT	Normal	Ears Normal Nose Normal Oropharynx Normal	*TMs Occluded* *Rhinorrhea / Epistaxis* *Erythema / Exudate / Dry Mucosa*	
Neck	Normal	Supple	*Nonsupple*	
Respiratory	Normal	Airway Patent CTA Breath Sounds Equal Respiration Nonlabored	*Airway Obstructed* *Crackles @ _____* *Rhonchi @ _____* *Wheezes @ _____* *Retractions*	
Cardiovascular	Normal	RRR Pulses Normal No Rub / Murmur	*IRR Tachycardia Bradycardia* *Abn. Pulses @ _____* *Murmur*	
GI / GU	Normal	Soft / Nontender No Masses Bowel Sounds Normal No Organomegaly	*Tender @ _____* *Mass @ _____* *Bowel Sounds Hypo Hyper* *Hepatomegaly / Splenomegaly*	
Musculoskeletal	Normal	Strength / ROM Intact No Edema No Calf Tenderness	*Limited @ _____* *Edema @ _____* *Calf Tenderness*	
Skin	Normal	Warm & Dry Color Normal	*Pale / Diaphoretic* *Cyanosis @*	
Neuro	Normal	Sensory / Motor Intact Reflexes Intact CN Intact A & O x 3	*Focal Deficit @ _____* *Abn. Reflex @ _____* *CN _____ Palsy* *A V P U Disoriented*	
Psychiatric	Normal	Affect / Mood Appropriate	*Anxious / Depressed*	

N/E

Level 1: 1 System Level 4: 4 Systems
Levels 2 - 3: 2 Systems Level 5: 6 systems

DIFFERENTIAL DIAGNOSES: Consideration of the following conditions may be warranted for the presenting problem; they are not final diagnoses.

Mother declined child to be examined; unless we write a note that she actually alleges. I have explained that I can only document what I could find & at that she left.

ED PHYSICIAN DIAGNOSES:

1. Refusal Examination
2.
3.

RE-EVALUATION: Pain Scale (0-10)

Time: _____ Unchanged Improved Worse VSS

Time: _____ Unchanged Improved Worse VSS

PHYS. NOTIFICATION/CONSULTS: *Chart Copy Available to Addt'l Care Providers*

Discussed disposition/case/management of patient with:

Name: _____ at _____ a.m. / p.m.

Name: _____ at _____ a.m. / p.m.

Admit/Transition Orders Written by ED Provider: Yes / No

Reviewed with: _____

Admit to: _____ Consult Follow-up: _____

DISPOSITION: * DISPOSITION DECISION TIME: _____

Discharge: Home Work Nursing Home Deceased AMA *LWBS

Admit: ED Obs InPt Unit: ICU OR Tele Floor Condition: Stable Unstable

Patient Endorsed To/Discussed With: _____ @ _____ a.m. / p.m.

Patient Stabilized Within Hospital's Capabilities/Transferred to: _____

_____ Transfer Form Completed

Disposition Rationale: _____

Discussed with: Patient Family Other: _____

After-Care Instructions Given to & Follow-Up Care Discussed w/Patient At Discharge

Critical Care Provided: 30-74 min / 75-104 min / _____ min. (Excludes time required for other billable procedures)

SIGNATURE: I have reviewed available Ancillary / Nursing Staff documentation.

TIME: _____

DATE (If different than above): _____

PA / NP / Resident

MD/DO

MD/DO

Teaching Physician - I performed a history & physical examination of the patient and discussed the management with the Resident. I reviewed the Resident's note and agree with the findings and plan of care, except as I have documented. _____ (Initials)

Chart Completed: Yes No

KRAMER, MADELINE H
VISIT ID: 11125434
01/20/2013 2Y/F
ATT: SABIR, MUHAMMAD
PCP: PERSAUD, PITAMBER
MRN: 261617

This form is to [illegible] are and treatment. It is not intended to supplant that judgement or create a standard of care.

DATE 05/13/2016

Order Sheet / General

Illinois Valley Community Hospital

~ TIME ALL ORDERS ~ | Obtain Medical Records: Old Chart Recent ED Chart Previous EKG Additional Records:

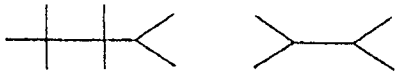
PANELS: Cardiac Stroke Abdominal Pain Trauma AMS Adult Sepsis Pediatric Fever STD / GYN Entered by: Time:

LABORATORY: Circle specific orders	By:	Time:
CBC w/Auto Diff Manual Diff Retic Count		
BMP CMP LFT Magnesium		
Amylase Lipase Ammonia		
UA C&S if Indicated Cath Urine Dip		
UCG HCG: Qual / Quant		
Drug Screen: Urine / Serum ETOH		
CPK CKMB Troponin		
D - Dimer BNP Myoglobin		
ESR Uric Acid		
Lactic Acid Cortisol		
PT / INR PTT DIC Panel		
Rh Type & Screen Type & Cross ____ units		
ASA Acetaminophen		
Digoxin		
Dilantin Depakote		
Tegretol Phenobarb		
Rapid Strep Mono RSV Influenza		
Stool: Leukocytes O & P Rotavirus		
GC Chlamydia Wet Prep KOH		
Hemoccult Gastroccult		
ABG On Room Air		
Cultures: Urine Sputum Wound		
Blood Blood x 2 Stool		
C. Difficile toxin		

RADIOLOGY: Circle specific orders	By:	Time:
CXR (2 view) Portable CXR		
C-Spine Port XT C-Spine		
3-View 5-View Flexion / Extension		
AAS KUB		
T-Spine L-Spine		
Ribs Right Left		
Finger Right Left		
Hand Right Left		
Wrist Right Left		
Forearm Right Left		
Elbow Right Left		
Humerus Right Left		
Shoulder Right Left		
Clavicle Right Left		
Hip Pelvis Right Left Portable		
Femur Right Left		
Knee Right Left		
Tibia / Fibula Right Left		
Ankle Right Left		
Foot Right Left		
CT: Head / Facial Bones Contrast: IV PO None		
CT: C-Spine T-Spine L-Spine		
CT: Chest Contrast: IV PO None		
CT: Abdomen / Pelvis Contrast: IV PO None		
Ultrasound of: GB ABD Pelvis		

Pertinent Lab Values: WNL WNL Except:

Patient Rh Status: Unknown Pos Neg



Indication(s) for Xray / CT / US: _____

Xray Interp: No Acute Changes Positive _____

By: ED Physician Radiologist _____

CARDIAC MONITOR / EKG INTERPRETATION:	By:	Time:
Monitor ✱▲ EKG		

Rate: Normal Brady Tachy
Rhythm: Sinus AFIB Junctional
Ectopy: None PVCs PACs

Axis: NL / Left / Right _____
ST Segment: Normal / _____
LBBB: New / Old / _____

EKG Interpretation: _____

EKG Comparison: No Significant Change / Other: _____

RESPIRATORY THERAPY:	Int/Tm	Int/Tm	Int/Tm
Albuterol Unit Dose or mg x 1 2 3 q min			
Atrovent Unit Dose or mg x 1 2 3 q min			
Xopenex Unit Dose or mg x 1 2 3 q min			
Rac Epi Unit Dose or mg x 1 2 3 q min			
Peak Flow: Pre-Tx: _____ Post-Tx #1: _____ Post-Tx #2: _____			

☐ *EKG Rhythm Strip:* Order and interpretation triggered by an event; to help diagnose the presence or absence of an arrhythmia.

TREATMENT ORDERS:	By:	Time:	Time:	CLINICAL RESPONSE / RE-EVALUATION
Repeat Vital Signs: All BP Pulse RR Temp O2 Sat				VSS except:
Pulse Ox O2 @ ____ l/min via NC / Mask / NRB				*Normal Hypoxic*
Saline Lock IV: NS LR Bolus ____ ml over ____ min / hr				____ % on R/A or O2 @ ____ l/min
Maintenance IV: NS LR ____ ml over ____ min / hr				
Disposition Orders: Discharge Admit to InPt Status Observation Transfer				

RE-EVALUATION: Unchanged Improved Worse

Time: _____ a.m. / p.m. _____

VSS except: _____ Pain: ____ (0-10)
Appearance: NAD / _____
Lungs: Clear / _____
Abdomen: Non-Tender / _____
Neuro: A & O x 3 / _____

SIGNATURE:

Time of Initial Orders: _____
Date: _____

_____ RN / Init
_____ RN / Init
_____ PA / NP / Resident
_____ MD / DO

KRAMER, MADELINE H
VISIT ID: 11125434
01/20/2013 2Y/F
ATT: SABIR, MUHAMMAD
PCP: PERSAUD, PITAMBER
MRN: 261617

DATE 05/13/2016

This form is to assist the healthcare provider's documentation of clinical care and treatment. It is not intended to supplant that judgement or create a standard of care.

Printed: 11/27/2015 19:27:02
Page 1 of 1

ILLINOIS VALLEY COMMUNITY HOSPITAL
Emergency Department Triage Report

Patient: KRAMER, MADELINE H.
Visit ID: 11125434
Age: 2Y DOB:01/20/2013 Sex: F Acuity: 4
Med Rec: 261617

Chief Complaint:	UTI complaints	Onset: 1 days	Head Circum.:
Triage D/T	11/27/2015 19:11	EMS:	Infection Control:
Room/Bed:	5	EMS Unit: Radio Call: N	
Arrival D/T:	11/27/2015 19:10	Pre Hospital Care:	
Arrived from:	Personal or public transportation	[None entered]	Screening: Child Abuse/Neglect, Safety
Mode of Arrival:	Ambulated		
Accompanied by:	Parent(s)		Suicide Risk: Screened - No Suicide Risk
Informant:	Parent(s)	Consent toTreat?:	Pregnant?: LMP:

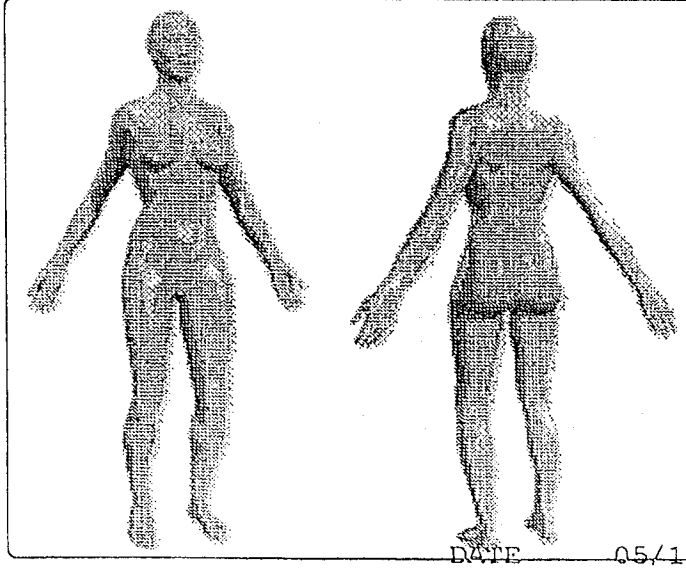
Patient Narrative:
mom reports pt c/o pain w/ urinating, smells "funny, like cheesy." mom c/o pt has diaper rash since returning from her dads home last night. pt seen at Edwards hospital last night.
[MURILLO, TARA 11/27/15 19:13]

Stroke Assessment Last Known Well:

NPO since: Last Intake Solid: D/T Last Intake Liquid: D/T

BP	Temperature	Pulse	Respirations	SpO_2	FSBS	GCS	Height
	98.0 F	130 bpm	24	98% 0 L/m		15	
Site:	Site: Forehead	Site:	Qty:	O_2Del: Room Air		M - 6	
Pos:		Qty:				V - 5	Weight
Type:		Type:				E - 4	14.06 kg

Pain Assessment	Score:0/10	Scale:	Location: 0
Character:			Non Verbal Signs:
Distribution:			Intensified By:
Radiation			Relieved By:
Duration:			Goal:



DATE 05/13/2016

Dr: (Unassigned)
PCP: OUT OF TOWN, PHYSICIAN
Electronically Signed By: MURILLO, TARA RN
Dt Signed: 11/27/2015 19:26:58

ILLINOIS VALLEY COMMUNITY HOSPITAL

Progress Notes Report

11/27/2015 19:10 Through 11/28/2015 05:17

Patient Name: KRAMER, MADELINE H.

Visit Id: 11125434 MR Number: 261617 DOB: 01/20/2013

Admit: 11/27/2015 19:10 Attending: MUHAMMAD SABIR

Assessment Date / Pt. Location	Department	Entry Date / Cosigned	Entered By
11/27/2015 19:59	ER	11/27/2015 19:59	MARIA C. ERNAT, RN

EMERGENCY DEPARTMENT ER 5

Mother of child presents pt to ER stating she is having pain with urination, redness around her vagina, and an odor to her vagina area that is similar to cheese/fish.

Nurse and doctor went into room to talk to mother in regards to child. Mother started explaining that she is suspicious that child is being harmed when she has visitations with her father. Mother stated that she brought child to Naperville hospital last night where they are recommending a swab or rape kit to be performed. Mother of child is requesting that doctor investigate if there are fluids present in or on the child that would suggest sexual assault.

Doctor explained to mother that rape kits on children of the childs age are not performed in this facility. Mother became contradictory in her thoughts in that she does not want a rape kit performed on her daughter, but that is what Naperville hospital is recommending.

Mother was insistant that she wanted doctor to perform an exam to find fluids on or in child. Doctor stated that he recommended her to seek help at a Children's Hospital. Mother then became insistant that she wanted doctor to write her a note stating what she wanted to be done, and that IVCH was not going to perform her requested exams.

Doctor stated that all he would write on discharge papers was a recommendation to a Children's hospital. Mother became increasingly angry and began to insult doctor stating, " your a man off the street, you dont know anything, your not even a real fucking doctor" Doctor then recommended that the woman keep her language down, and that she leave the facility and return to Naperville hospital to seek out the medical help they are recommending.

DATE 05/13/2016

NOTE: All strikeouts were executed by person making original entry.
* Significant Finding

Fax Transmission

EDWARD ELMHURST HEALTH INFORMATION DEPARTMENT
801 S. WASHINGTON STREET
NAPERVILLE, ILLINOIS 60540
Dept Phone: 331-221-6990
Dept Fax: 331-221-2390

Date: 10/13/16

To: COMMUNITY HEALTH PARTNERSHIP OF ILLINOIS

Phone Number:
Fax Number: 815-539-9015

SENT FROM:
FAXED FROM:
SENDER PHONE NUMBER:
PURPOSE: OTHER HEALTHCARE FACILITY
INFO RELEASED:ABSTRACT OF HEALTH INFORMATION
RELEASE ID: 3136972

Subject: Request for Medical Records
Comments: You are receiving this in response to a request for medical record information.

Resp Ex #2

06 LPN
11-7-14

Edward Hospital Emergency Department
801 S Washington St
NAPERVILLE IL 60540-7430

KRAMER,MADELINE
MRN: EH2173990
DOB: 1/20/2013, Sex: F
Adm: 10/3/2016, D/C: 10/3/2016

Patient Demographics

Address
2830 4th STREET lot 13
PERU IL 61354

Phone
815-876-7479 (Home)
815-876-7479 (Mobile) *Preferred*

Admission Information - Patient Record Only

Arrival Date/Time:	10/02/2016 11:53 PM	Admit Date/Time:	10/03/2016 12:08 AM	IP Adm. Date/Time:	None
Admission Type:	Emergency	Point of Origin:	Clinic Or Physician's Office	Admit Category:	None
Means of Arrival:	Car	Primary Service:	Emergency Medicine	Secondary Service:	N/A
Transfer Source:	None	Service Area:	Edward/linden Hospital	Unit:	Eh Emergency Dept
Admit Provider:	None	Attending Provider:	Schutte, Martin, MD	Referring Provider:	None

Discharge Summaries

No notes of this type exist for this encounter.

Edward Hospital Emergency Department
801 S Washington St
NAPERVILLE IL 60540-7430

KRAMER,MADELINE
MRN: EH2173990
DOB: 1/20/2013, Sex: F
Adm: 10/3/2016, D/C: 10/3/2016

ED Notes

ED Notes by Mateyack, Marykathryn S, RN at 10/3/2016 7:06 AM

Author: Mateyack, Marykathryn S, RN | Service: (none) | Author Type: Registered Nurse
Filed: 10/3/2016 7:09 AM | Note Time: 10/3/2016 7:06 AM | Status: Signed
Editor: Mateyack, Marykathryn S, RN (Registered Nurse)

DCFS RETURNED OUR CALL = AMY/DCFS UPDATED ON THIS PT'S HISTORY AND TODAY'S VISIT. GIVEN INFO ON PERU PD AND INFO ON PT'S DAD. INTAKE #13280933. AS OF THIS NOTE THE PERU POLICE DEPT HAS NOT PICKED UP THE EVIDENCE KIT. SEE PREV NOTE .

Electronically signed by Mateyack, Marykathryn S, RN on 10/3/2016 7:09 AM

ED Notes by Mateyack, Marykathryn S, RN at 10/3/2016 3:30 AM

Author: Mateyack, Marykathryn S, RN | Service: (none) | Author Type: Registered Nurse
Filed: 10/3/2016 4:27 AM | Note Time: 10/3/2016 3:30 AM | Status: Signed
Editor: Mateyack, Marykathryn S, RN (Registered Nurse)

Call placed to DCFS = message left with Ashlyn for their associate to contact this RN at ED. DCFS form completed and copy to chart and Ped Abuse Binder and Chg nurse desk.

Electronically signed by Mateyack, Marykathryn S, RN on 10/3/2016 4:27 AM

ED Notes by Mateyack, Marykathryn S, RN at 10/3/2016 3:47 AM

Author: Mateyack, Marykathryn S, RN | Service: (none) | Author Type: Registered Nurse
Filed: 10/3/2016 4:20 AM | Note Time: 10/3/2016 3:47 AM | Status: Signed
Editor: Mateyack, Marykathryn S, RN (Registered Nurse)

Call place to Peru Police Dept: 815.223.2151 - spoke to Tony re kit completed and ready to be picked up at ED.

Electronically signed by Mateyack, Marykathryn S, RN on 10/3/2016 4:20 AM

ED Notes by Mateyack, Marykathryn S, RN at 10/3/2016 2:45 AM

Author: Mateyack, Marykathryn S, RN | Service: (none) | Author Type: Registered Nurse
Filed: 10/3/2016 4:18 AM | Note Time: 10/3/2016 2:45 AM | Status: Signed
Editor: Mateyack, Marykathryn S, RN (Registered Nurse)

All paper work from kit completed with 5 miscellaneous specimen envelopes labeled and sealed per protocol. Kit then sealed in front of mom and kept in this RN possession until locked in Peds Evidence Locker with Cathy,RN.

Electronically signed by Mateyack, Marykathryn S, RN on 10/3/2016 4:18 AM

ED Notes by Mateyack, Marykathryn S, RN at 10/3/2016 2:15 AM

Author: Mateyack, Marykathryn S, RN | Service: (none) | Author Type: Registered Nurse
Filed: 10/3/2016 4:13 AM | Note Time: 10/3/2016 2:15 AM | Status: Signed
Editor: Mateyack, Marykathryn S, RN (Registered Nurse)

Edward Hospital Emergency Department
801 S Washington St
NAPERVILLE IL 60540-7430

KRAMER,MADELINE
MRN: EH2173990
DOB: 1/20/2013, Sex: F
Adm: 10/3/2016, D/C: 10/3/2016

ED Notes (continued)

ED Notes by Mateyack, Marykathryn S, RN at 10/3/2016 2:15 AM (continued)

Pt's mom updated on kit while pt remains sleeping. Mom and this RN remained at bs while Dr Schutte examined pt while she slept. Mom signed permission for kit collection and verbalized understanding of swabs and agreed to give the pt's underpants for the kit - place in clothing paper bag, completed label and bag then sealed with evidence tape. Specimens collected from right and left nipple,umbilicus, external genitalia and vaginal wash with sterile water completed per protocol.

Electronically signed by Mateyack, Marykathryn S, RN on 10/3/2016 4:13 AM

ED Notes by Mateyack, Marykathryn S, RN at 10/3/2016 1:50 AM

Author: Mateyack, Marykathryn S, RN | Service: (none) | Author Type: Registered Nurse
Filed: 10/3/2016 4:05 AM | Note Time: 10/3/2016 1:50 AM | Status: Signed
Editor: Mateyack, Marykathryn S, RN (Registered Nurse)

Pt's mom refused to sign release form for YWCA but accepted the information packet given to her by Abby.

Electronically signed by Mateyack, Marykathryn S, RN on 10/3/2016 4:05 AM

ED Notes by Mateyack, Marykathryn S, RN at 10/3/2016 1:45 AM

Author: Mateyack, Marykathryn S, RN | Service: (none) | Author Type: Registered Nurse
Filed: 10/3/2016 4:04 AM | Note Time: 10/3/2016 1:45 AM | Status: Signed
Editor: Mateyack, Marykathryn S, RN (Registered Nurse)

Abby YWCA arrived and updated on pt's history. Bedside report then given to pt's mom while pt slept.

Electronically signed by Mateyack, Marykathryn S, RN on 10/3/2016 4:04 AM

ED Notes by Mateyack, Marykathryn S, RN at 10/3/2016 1:25 AM

Author: Mateyack, Marykathryn S, RN | Service: (none) | Author Type: Registered Nurse
Filed: 10/3/2016 4:03 AM | Note Time: 10/3/2016 1:25 AM | Status: Signed
Editor: Mateyack, Marykathryn S, RN (Registered Nurse)

Call to YWCA/sass = Abby returned call and her eta 20 minutes.

Electronically signed by Mateyack, Marykathryn S, RN on 10/3/2016 4:03 AM

ED Notes by Mateyack, Marykathryn S, RN at 10/3/2016 1:14 AM

Author: Mateyack, Marykathryn S, RN | Service: (none) | Author Type: Registered Nurse
Filed: 10/3/2016 4:01 AM | Note Time: 10/3/2016 1:14 AM | Status: Signed
Editor: Mateyack, Marykathryn S, RN (Registered Nurse)

Call placed to Peru police dept at 815.223.2151 spoke to officer Kowalczyk badge # P26 and given pt's dad:Kevin Kramer parents' address where pt was taken for Sunday's visit.
Grandparents:Mary and Joseph Kramer @1628 First Street,Peru IL 61354. Pt's great uncle also lives at address Joseph Mignone - all provided by pt's mom.

Electronically signed by Mateyack, Marykathryn S, RN on 10/3/2016 4:01 AM

Edward Hospital Emergency Department
801 S Washington St
NAPERVILLE IL 60540-7430

KRAMER,MADELINE
MRN: EH2173990
DOB: 1/20/2013, Sex: F
Adm: 10/3/2016, D/C: 10/3/2016

ED Notes (continued)

ED Notes by Mateyack, Marykathryn S, RN at 10/3/2016 1:14 AM (continued)

ED Notes by Mateyack, Marykathryn S, RN at 10/3/2016 12:30 AM

Author: Mateyack, Marykathryn S, RN | Service: (none) | Author Type: Registered Nurse
Filed: 10/3/2016 3:57 AM | Note Time: 10/3/2016 12:30 AM | Status: Signed
Editor: Mateyack, Marykathryn S, RN (Registered Nurse)

Mom at bs with pt now sleeping, states pt was visiting her dad and arrived home tonight with stained underpants. Pt's mom provided name and address of pt's dad and informed we had to notify the Peru police where dad lives. Mom also notified we will be call dupage sass and they will have an info packet for her. Pt' s mom updated on poc and approximate time frame.

Electronically signed by Mateyack, Marykathryn S, RN on 10/3/2016 3:57 AM

ED Provider Notes by Schutte, Martin, MD at 10/3/2016 1:25 AM

Author: Schutte, Martin, MD | Service: (none) | Author Type: Physician
Filed: 10/3/2016 2:14 AM | Note Time: 10/3/2016 1:25 AM | Status: Signed
Editor: Schutte, Martin, MD (Physician)

Patient Seen In: Edward Hospital Emergency Department

History

Patient presents with:
Eval-G (gynecologic)
Eval-S (psychosocial)

Stated Complaint: EVAL G

HPI

Patient is a 3-year-old brought to the emergency department at midnight by mom with a concern per mom that tonight the child had visitation with her father, and after coming home the child was complaining of pain in the perineal area, mom noted that there was some greenish discharge in the area, in the underwear, so she came to the emergency department after calling and speaking with the pediatric emergency department here.

No other symptoms. The child is not giving any history. History is obtained from mom.

History reviewed. No pertinent past medical history.

History reviewed. No pertinent past surgical history.

Medications:
Not on File

Edward Hospital Emergency Department
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NAPERVILLE IL 60540-7430

KRAMER,MADELINE
MRN: EH2173990
DOB: 1/20/2013, Sex: F
Adm: 10/3/2016, D/C: 10/3/2016

ED Notes (continued)

ED Provider Notes by Schutte, Martin, MD at 10/3/2016 1:25 AM (continued)

No family history on file.

Smoking Status: Never Smoker

Review of Systems

Positive for stated complaint: EVAL G
Other systems are as noted in HPI.
Constitutional and vital signs reviewed.

All other systems reviewed and negative except as noted above.

PSFH elements reviewed from today and agreed except as otherwise stated in HPI.

Physical Exam

ED Triage Vitals		
BP	--	
Pulse	10/03/16 0004	**142**
Resp	10/03/16 0004	**28**
Temp	--	
Temp src	--	
SpO2	10/03/16 0004	**97 %**
O2 Device	10/03/16 0004	**None (Room air)**

Current:Pulse 142 | Resp 28 | Wt 14.8 kg | SpO2 97%

Physical Exam

Child appears comfortable and well hydrated.

Head: Normocephalic and atraumatic.

Sclera anicteric, conjunctiva pink and moist.

ucus membranes pink and moist, pharynx normal appearance without lesions.

No trismus or stridor

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ED Notes (continued)

ED Provider Notes by Schutte, Martin, MD at 10/3/2016 1:25 AM (continued)

Neck: Supple with normal full range of motion.

Chest: Nontender, clear breath sounds , no tachypnea or retractions, no cough

Heart: Regular rate and rhythm , good peripheral pulses.

Abdomen: Soft, Without any tenderness or mass. External genitalia examination with RN and mom, reveals minimal erythema at the labia bilaterally, no bleeding, no lacerations. 1 mm x 4 mm area of yellow/ greenish discharge adjacent to the urethra, no ecchymosis. External anal examination is unremarkable.

Back: Skin appears normal.

Extremities: Warm, well perfused, without apparent injury

Skin: Without acute lesions, contusions, or ecchymosis

Neurologic: Awake and alert , acting grossly appropriate for age and situation, time of day

ED Course

Labs Reviewed - No data to display
We have notified police and DCFS/ YWCA.

Patient and mom seen here by YWCA.

We have spoken with our child advocate specialist and will perform the kit and collect samples per their specific recommendations.

I encouraged mom to follow-up tomorrow or the next day at the latest with the pediatrician for reexamination and further outpatient treatment if indicated.

MDM

The usual and customary discharge instuctions were discussed given the patient's ER course.

We discussed signs and symptoms that should prompt the patient's immediate return to the emergency department, they voice understanding.
Reasonable over the counter and prescription treatment options and Physician follow up plan was discussed.
The patient is discharged home in good condition.

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ED Notes (continued)

ED Provider Notes by Schutte, Martin, MD at 10/3/2016 1:25 AM (continued)

Disposition and Plan

Clinical Impression:
Assault, alleged (primary encounter diagnosis)

Disposition:
There is no disposition on file for this visit.

Follow-up:
Loux, Holly A, MD
4043 State Rte 59
Naperville IL 60564
630-420-4275

In 1 day
As we discussed for repeat exam, workup as needed

Medications Prescribed:
There are no discharge medications for this patient.

Electronically signed by Schutte, Martin, MD on 10/3/2016 2:14 AM

ED Initial Assessment (HPI) by Mander, Michelle C at 10/2/2016 11:59 PM

Author: Mander, Michelle C
Filed: 10/3/2016 12:03 AM
Editor: Mander, Michelle C (Registered Nurse)
Service: (none)
Note Time: 10/2/2016 11:59 PM
Author Type: Registered Nurse
Status: Signed

Present with mother for Eval G possible Eval S. Mother states patient went for a 6 hour visitation today with father, returned home at 2100 mother noted green and yellow discharge in patients underwear, patient telling mother that her private area is sore. Patient very irritable upon return to mother.

Electronically signed by Mander, Michelle C on 10/3/2016 12:03 AM

Discharge Information - Patient Record Only

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
10/03/2016 3:40 AM	Home Or Self Care	Home	None	Eh Emergency Dept

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History & Physicals
No notes of this type exist for this encounter.

Surgery Report

Anesthesia Post-Op Notes
No notes of this type exist for this encounter.

Procedure Reports
No notes of this type exist for this encounter.

Consult Reports
No notes of this type exist for this encounter.

Progress Notes
No notes of this type exist for this encounter.

Psychiatric Evaluation
No notes of this type exist for this encounter.

All Results
No results found

Encounter-Level Documents:
There are no encounter-level documents.